I am Beatrice Braun from Spring Hill, Florida and a member of AARP's Board of Directors. Thank you for the opportunity to discuss with you today the need for a prescription drug benefit in Medicare.

The Medicare program has been, is, and will likely remain the nation's principal source of health benefits and a key source of financial protection for older Americans and those with disabilities. The program also provides financial protection for the families of Medicare beneficiaries, and it further serves younger Americans with its guarantee of future protection as they plan their retirements. In addition, Medicare is a strong and stable underpinning of the financing of our nation's health care system.

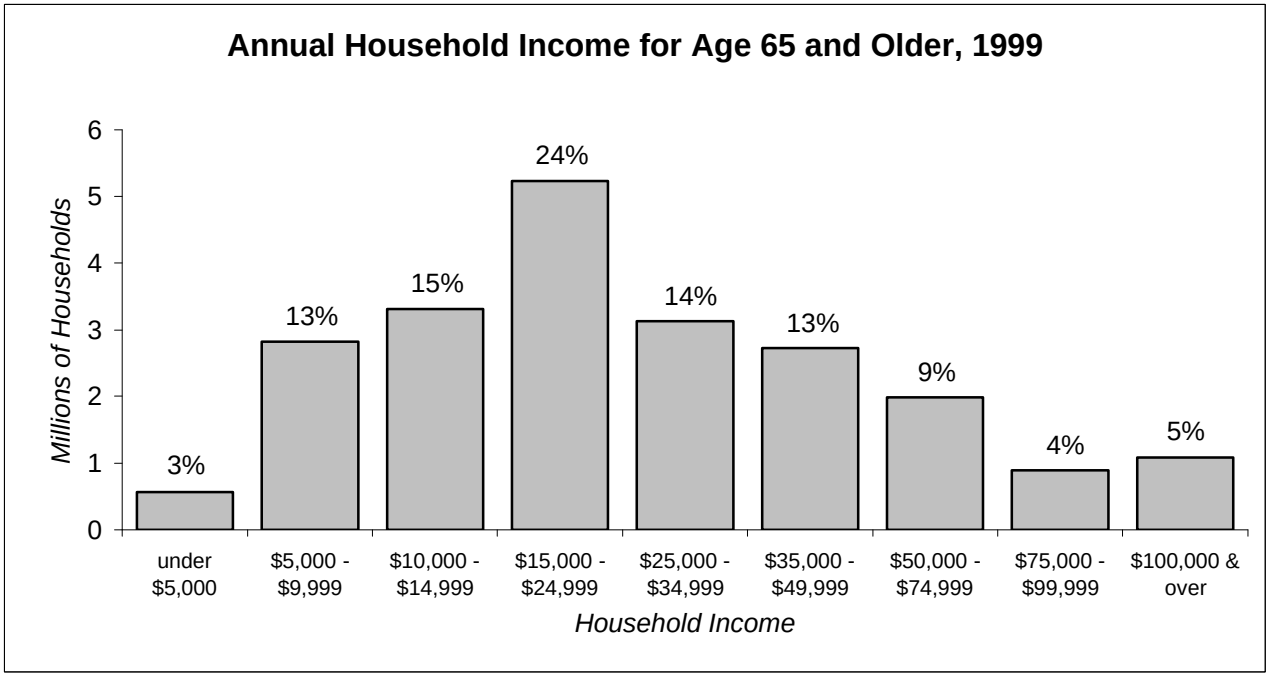
As we examine approaches to updating Medicare, it is essential that we modernize the Medicare benefit package. In particular, it is time to add an outpatient prescription drug benefit in recognition of the changing health care technology that has made prescription drugs an increasingly important – now central – component of modern medical care. A prescription drug benefit in Medicare would improve the quality of health care received by millions of older Americans. It could reduce unnecessary hospitalizations and shorten nursing home stays. A well-managed benefit also offers the potential to reduce the risks of drug interactions and polypharmacy by helping to assure that beneficiaries are taking the right medications in the correct dosages. It makes no more sense to have a Medicare program today without prescription drug coverage than it would to have a program that excludes inpatient hospital or physician coverage.

Background

Medicare today – while the centerpiece of health benefits protection for retirees and those with disabilities – covers only about half of the health spending of older Americans. Further, Medicare beneficiaries spend a significant share of their income on health care. In 2000, out-of-pocket costs for older beneficiaries averaged $2,580 or 19 percent of their income. While Social Security and Medicare have done a wonderful job in assuring a floor of income support and financial protection for older Americans, the fact remains that increasing health costs for older individuals coupled with lower incomes in their retirement years often makes the costs of uncovered benefits unaffordable.

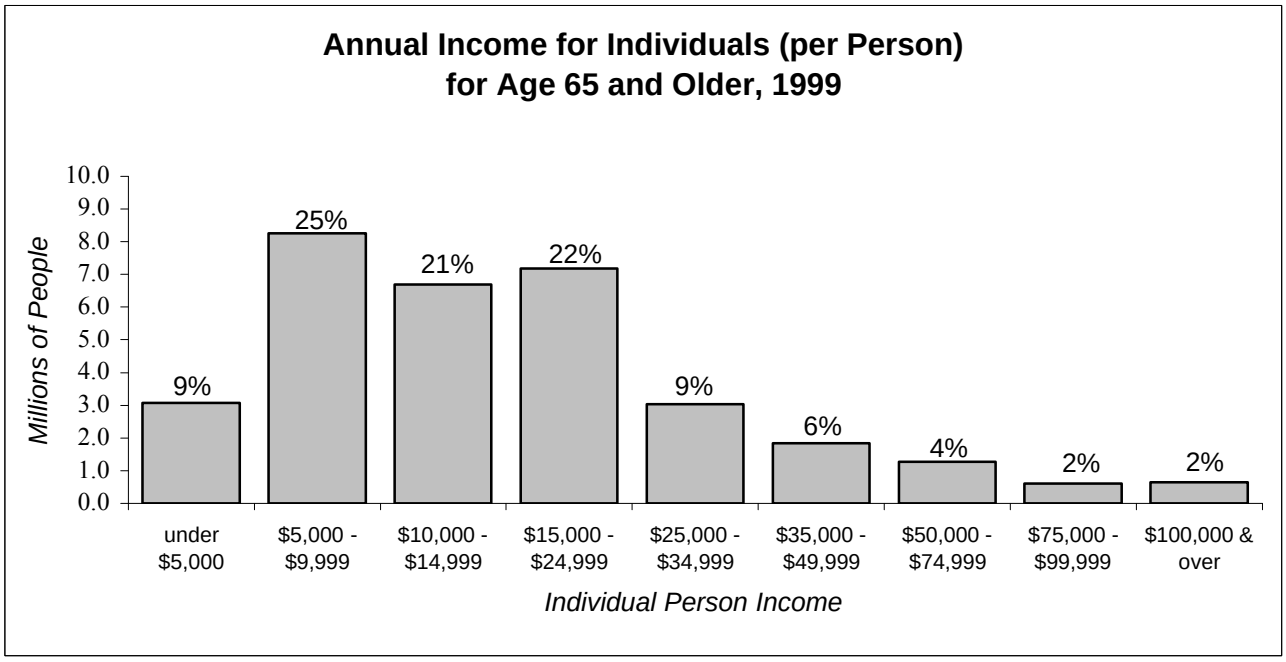
As illustrated in Charts 1 and 2, more than half of individuals age 65 and older live in households where the total income is less than $25,000 per year. Looked at another way, more than half of individuals over 65 have per capita income of less than $15,000 per year. Fewer than 10 percent of individuals and fewer than 20 percent of households had income over $50,000 in 1999.

Chart 1



Source: AARP PPI analysis of CPS.

Chart 2



Source: AARP PPI analysis of CPS.

The Need for a Prescription Drug Benefit in Medicare

Over the last two decades, the lack of prescription drug coverage has become a critical gap in the Medicare program as modern medicine has turned increasingly to drug treatments. Our nation's long-term investment in biomedical research has yielded enormous scientific progress – and the recent budgetary commitment to doubling the NIH budget highlights our intent to continue that progress. Those investments, coupled with the pharmaceutical industry's spending on research and development, have yielded an array of medications that could not have been even imagined when Medicare was enacted in 1965.

Private health benefit plans throughout the nation generally have kept pace with these advances in their benefits for workers. Employers have recognized the longer-term economic and health care value of providing coverage for prescription drugs. Medicare should do the same. According to a 2000 Mercer/Foster Higgins survey, 99

percent of employer-sponsored health plans offered outpatient prescription drug coverage to current workers. However, employers are finding it increasingly difficult to offer health benefits to retirees to supplement their Medicare protection. As a result, health care coverage for retirees is plummeting. An estimated 60 to 70 percent of large employers offered retiree health benefits in the 1980s. But by 1993 only 40 percent of employers with 500 or more employees offered health benefits to future Medicare-eligible retirees, and by 2000 this number had dropped even further to 24 percent [2000 Mercer/Foster Higgins Survey (forthcoming)]. Of employers who do offer retiree benefits, 21 percent do not include prescription drug coverage for Medicare-eligible retirees. Moreover, a recent Hewitt survey of large employers indicates that 36 percent of those employers are considering cutting back on prescription drug coverage for Medicare-eligible retirees over the next three to five years.

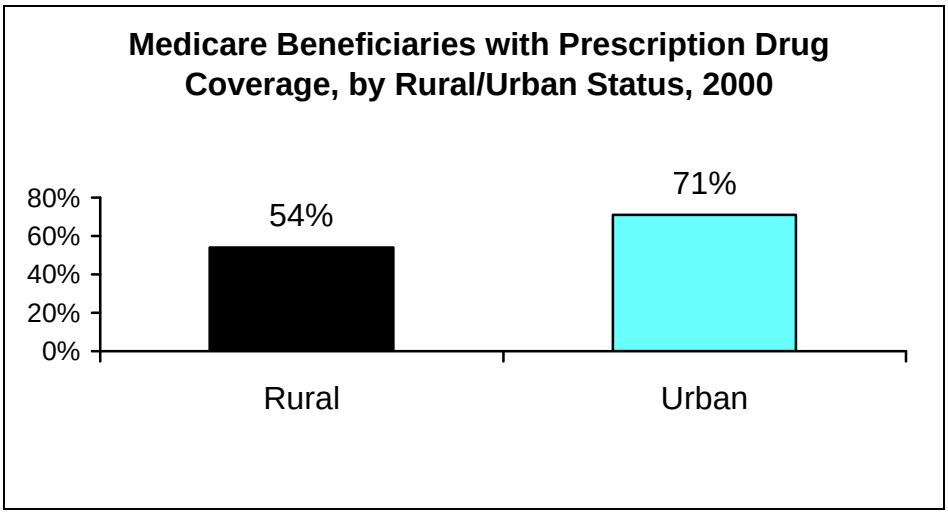
Other major sources of prescription drug coverage for Medicare beneficiaries are also proving inadequate or undependable. Medigap plans provide prescription drug coverage in only three of the standard ten plans, and these plans place limits on the benefit, including a 50 percent coinsurance and caps on the benefit at either $1,250 or $3,000 annually. Roughly 600,000 Medicare beneficiaries are enrolled in one of the standardized Medigap plans (H, I, or J) that cover prescription drugs. Another group of beneficiaries are enrolled in pre-standardized Medigap plans that provide some prescription drug coverage, but those plans generally have even more limited prescription drug coverage.

Medicare+Choice plans are another source of prescription drug coverage. In the mid-1990s growing numbers of beneficiaries began moving to Medicare HMOs, often to take advantage of the prescription drug coverage they were offering. But today, many of these plans are dropping out of Medicare, making such coverage very unstable for beneficiaries. In 2001, 30 percent of Medicare+Choice plans do not offer a drug benefit at all, meaning that only 3.8 million Medicare+Choice enrollees have prescription drug coverage. In addition, many Medicare+Choice plans that have

remained in the program have increased their premium charges or reduced benefits; most noticeably for prescription drugs. In 1999, 78 percent of Medicare+Choice enrollees were in basic plans that charged zero premiums and offered some drug coverage; this has dropped to 35 percent in 2001. HCFA has not yet released additional information that describes Medicare+Choice prescription drug benefits in 2001, but we have no reason to believe that there has been any expansion of the benefit.

Without Medicare coverage of prescription drugs, older Americans must depend on supplemental sources of financing for their medications or pay for them directly out-of-pocket. On average, an estimated one-third of Medicare beneficiaries lack prescription drug coverage. However, this figure obscures the variations in drug coverage among certain subgroups of beneficiaries. For example, as shown in Chart 3, a much smaller share of Medicare beneficiaries in rural areas have some form of supplemental drug coverage than do beneficiaries in urban areas.

Chart 3



Source: AARP PPI analysis using the Medicare Benefits Model, version 4.10.

Moreover, prescription drug coverage data – which focus on coverage at one point in time – obscure the problem of obtaining continuous coverage. While the data indicate roughly two-thirds of beneficiaries have drug coverage at some point during a

year, recent research indicates that only 53 percent of beneficiaries have prescription drug coverage for the entire year.

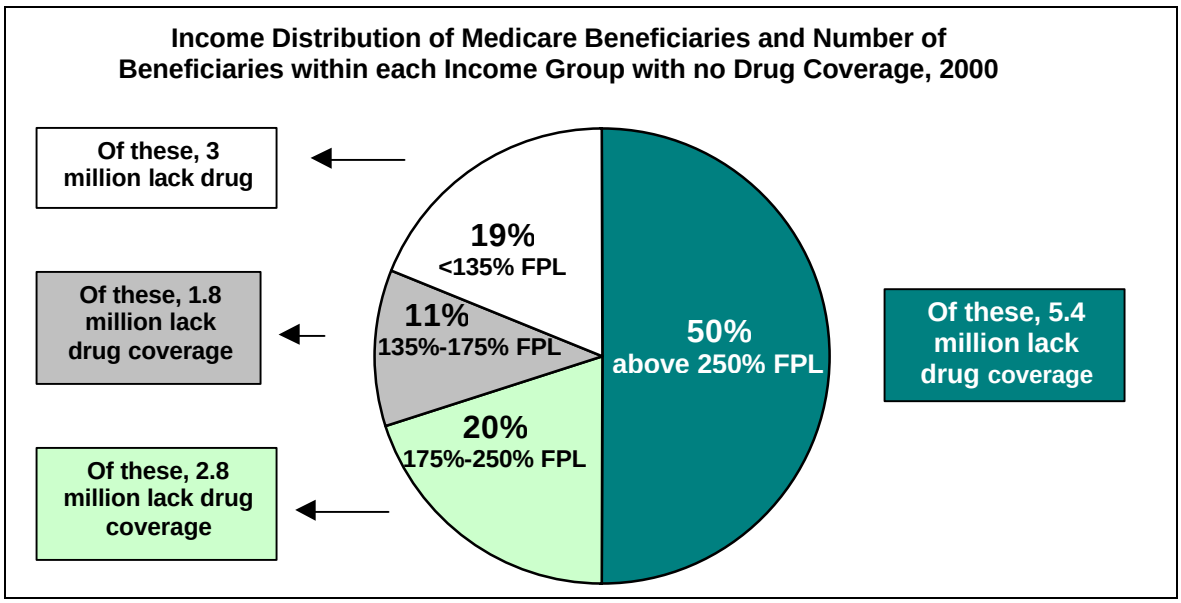
The rising cost of prescription drugs, their large and growing role in good medical care, and the gaps in Medicare beneficiaries' current coverage for medications reinforce the need for a prescription drug benefit that extends to all Medicare beneficiaries. While there has been some discussion of a benefit that would extend only to low-income beneficiaries, this approach has been increasingly recognized as inadequate since a large number of older and disabled Americans with incomes above 175 percent of the federal poverty level lack drug coverage. As Chart 4 illustrates, an estimated 8.2 million beneficiaries above 175 percent of the federal poverty level ($14,600 for singles, $19,700 for couples in 2000) lacked any coverage for prescription drugs in 2000. [1]

[1] The following table presents the 2001 poverty guidelines published in the Federal Register, February 16, 2001, pages 10695-10697, for singles and couples. Income measures for the near-poor and moderate income are also included.

2001 Poverty Guidelines

	Single	Couple
48 States and DC	$ 8,590	$11,610
Alaska	$10,730	$14,510
Hawaii	$ 9,890	$13,360
48 States and DC		
100 Percent of Poverty	$ 8,590	$11,610
125 Percent of Poverty	$10,738	$14,513
135 Percent of Poverty	$11,597	$15,674
150 Percent of Poverty	$12,885	$17,415
175 Percent of Poverty	$15,033	$20,318
200 Percent of Poverty	$17,180	$23,220
250 Percent of Poverty	$21,475	$29,025

Chart 4



Source: AARP PPI analysis using the Medicare Benefits Model, version 4.10.

AARP's Policy Approach to a Prescription Drug Benefit

The coverage gap in Medicare is clear. Medicare is the basic health plan for the population that is most in need of these new tools of modern medicine, but it does not cover prescription drugs. For current and future Medicare beneficiaries a prescription drug benefit would improve the quality of their health care and even their quality of life. AARP is committed to creating a prescription drug benefit in Medicare and has identified fundamental design features for developing a prescription drug benefit.

In the simplest terms, a prescription drug benefit under Medicare needs to be available and affordable to all beneficiaries.

To understand what this means, it is first necessary to recognize the general consensus among most players that a prescription drug benefit in Medicare should be a voluntary benefit. This conclusion is based on the fact that some beneficiaries, as noted above, do have alternative sources of coverage. Beneficiaries need to be able to keep the benefits that they currently have if they choose to do so.

Designing a viable voluntary benefit, however, requires careful attention to how to make the benefit widely available and affordable. Availability must be nationwide. Beneficiaries all over the country – living in rural, suburban, and urban areas – must be assured that the drug benefit is not only going to be a part of Medicare+Choice plans wherever feasible, but that it will also always be available in their community to accompany the traditional Medicare fee-for-service plan.

The benefit must also be affordable, which means not only that premiums and cost-sharing must be reasonable, but also that healthy as well as sick beneficiaries see it as a "good buy." Affordability is a critical feature in assuring that this new benefit actually helps beneficiaries gain access to their new coverage and benefit from the prescriptions that their physicians determine are necessary for their health. But the implications of affordability go far beyond that, especially in the design of a viable voluntary program.

In any voluntary insurance arrangement, affordability for the individual is essential to assure that a substantial portion – and broad mix – of eligible individuals actually enroll. Making enrollment attractive and affordable requires a careful balance of covered benefits and government premium subsidies. The government contribution for a drug benefit in Medicare, as in any well-designed employer plan, must be adequate to assure enrollment of a balanced risk pool of enrollees. Part B of Medicare – a voluntary program in which 95 percent of Medicare beneficiaries participate – is a model in this regard. Without a broad-based risk pool, a voluntary benefit will attract a disproportionate number of beneficiaries with high prescription drug costs, prompting a rapid rise in benefit premiums.

Medicare has always benefited from being a defined benefit plan, and we believe that approach should apply to the implementation of a prescription drug plan as well. A defined benefit package is readily understood by beneficiaries and their families, and provides dependability and certainty for beneficiaries planning for the

future. In addition, a defined benefit is an important element in lessening selection problems and instability that result from plan design, sometimes known as "cherry picking."

Affordability also requires that there be adequate mechanisms and incentives to constrain the rate of increase in spending under the program and to ensure that beneficiaries and other taxpayers receive value for their premium and tax dollars. Cost constraint cannot simply involve shifting of costs to beneficiaries, nor can it rely on arbitrary underpayments to providers – in this case pharmacies and drug manufacturers. It should feature drug-purchasing strategies that enable beneficiaries and Medicare to take advantage of the purchasing power of the program. Further, the program must make available reliable, objective, and understandable information that allows providers and beneficiaries to make the best choices among the treatments available to them.

Affordability in any new prescription drug program also requires additional subsidies for beneficiaries with low incomes, for whom the traditional Medicare premium and cost-sharing would be simply unaffordable. Improvements are needed in the current income protections available to low-income beneficiaries. In particular, the income thresholds for eligibility need to be increased and program participation must grow. The current programs, known as the Qualified Medicare Beneficiary (QMB) program and the Specified Low-Income Medicare Beneficiary program (SLMB), are funded through the Medicaid program and pay for the Medicare premiums, deductibles and coinsurance of beneficiaries below certain income thresholds. It is essential that similar protections complement a prescription drug benefit and continue to be funded through Medicaid to help low-income beneficiaries pay for their prescription drug and other Medicare services. While a prescription drug benefit under Medicare must not be limited to individuals with low incomes, nationwide availability for all beneficiaries must be coupled with extra support for those who have low incomes.

Finally, amidst all of the features of program design, we need to keep attention focused on the reason for the prescription drug benefit – access to medically appropriate drug therapies. The new benefit design must include the right to a timely appeal and external review of coverage denials, as well as quality improvement components that reduce medication errors and mismedication – thereby improving quality of care and reducing overall health costs.

Medicare Reform

Part of the debate over adding a prescription drug benefit in Medicare is whether – and to what extent – additional changes to Medicare are necessary. Proponents of completely restructuring Medicare argue that the program is antiquated, unable to respond to the changing health care marketplace, and in need of a major overhaul.

We agree that some changes in Medicare are necessary to modernize the program, secure its long-term financial future, and ready it to handle retirement of the "baby boom" generation. We believe that incremental, step-by-step improvements can begin to make a significant difference in the success of the program and would be far less disruptive to current and future beneficiaries than an abrupt and comprehensive overhaul. Under any scenario, however, Medicare's defined benefit must be preserved.

To that end, this Committee is to be commended for convening the task force that is assessing the oversight of the Medicare program. Effective administration of Medicare is critical and changes that enable the agency that oversees the program to better serve beneficiaries and providers should be considered. We encourage the Committee to give serious consideration to some of the recommendations made last week by the four previous Administrators of the Health Care Financing Administration (HCFA).

In particular, AARP believes strongly that beneficiary education and outreach efforts must be expanded and adequately funded. Beneficiaries must have good information in order to make the right choices about their health care options. We also believe that a program that serves 40 million Americans, processes roughly 1 billion claims a year, and is responsible for overseeing beneficiaries' quality of health care needs a modern, efficient information technology system. In this regard, the current constraints on Medicare's administrative costs should be reevaluated as part of any reform.

In broader terms, the administration of Medicare must be structured in such a way as to prevent fragmentation of the program and to guarantee seamless operation of traditional fee-for-service, private plan options and any prescription drug benefit. The administering agency must remain fully accountable to Members of Congress and to beneficiaries. And, the agency that oversees Medicare must have the tools and the flexibility it needs – such as the ability to modernize fee-for-service so that it remains a viable option for beneficiaries – to continue to improve the program.

Conclusion

In many respects it seems only a statement of the obvious to say that Medicare beneficiaries need a prescription drug benefit in Medicare. Americans age 65 and older account for over one-third of all drug spending, but represent only about 12 percent of the population. Our nation's health care system relies more and more on prescription drugs to provide high quality care for acute and chronic conditions. Prescription drugs make us well, and they keep us from getting sick. Most private health benefit plans throughout the nation have kept pace with these advances in their benefits for workers, but Medicare has not. That must change.

It will not be an easy change, and it will involve trade-offs on the part of all players. Nevertheless, it must be done so that all older and disabled Americans can be assured that they will have the option of enrolling in an affordable Medicare prescription drug benefit.

AARP believes that there are important principles that must be followed in the development of a drug benefit; we have outlined those in this testimony. We are ready to continue to work with this Committee, the Congress, and the Administration to help shape a benefit in Medicare that will be affordable and viable, and will make room for the changing role of pharmaceuticals in medicine.